

# Health Care Reform and the Trustee's Role

*The American Hospital Association's*



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# Monograph Series

### **About the Author**

John R. Combes, M.D. is President and Chief Operating Officer of the American Hospital Association's Center for Healthcare Governance. He can be reached at [jcombes@aha.org](mailto:jcombes@aha.org).

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Center for Healthcare Governance  
155 North Wacker Drive Suite 400  
Chicago, Illinois 60606  
Phone: (888) 540-6111  
[www.americangovernance.com](http://www.americangovernance.com)

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## Overview

Comprehensive health care reform legislation became law earlier this year. It was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The final, amended version of the law is known as the Affordable Care Act (ACA). The law will go into effect over time, with September 23, 2010, marking the starting point for various reforms.

There are multiple parts to the bill, many requiring development of regulations by the Centers for Medicare and Medicaid Services. Consequently, there will be a lot of work done behind the scenes to implement the bill and many demonstration projects conducted to test innovative approaches to fulfill the bill's intent and requirements.

The passage of health care reform legislation has several implications for trustees, who must not only understand the legislation, but also how it impacts their organizations and what it means for governance.

Much uncertainty still exists around the implications of the health care reform bill. But three things are certain. For hospitals, health care reform will result in more integration, more accountability and more risk. In the current climate of reform, the role of trustee has never been more critical to the success of our hospitals and systems—and the challenges have never been greater. This monograph will review key components of the new law and suggest strategies boards can pursue to guide and govern their organizations through the changes and challenges ahead.

## Coverage

The Affordable Care Act will expand coverage to 32 million new individuals by 2019. This process will begin in January, 2014 and will include a combination of public program expansions and private sector health insurance reforms. All U.S. citizens and legal residents will be required to obtain coverage or face tax penalties. Those without employer plans will be able to obtain coverage through “health insurance exchanges” which will exist, primarily, at the state level. In addition, subsidies will be available to assist low-income individuals to pay health insurance premiums, and Medicaid will be expanded to provide coverage for the poor. While employers will not be required to provide coverage, large employers will be charged a “free rider” assessment if their employees purchase health care coverage through the exchange.

## The Massachusetts Experience

Massachusetts has led the nation in health care reform. Enacted in 2006, the Massachusetts Health Care Insurance Reform Law requires every resident of the state to obtain a state-regulated minimum level of health care insurance coverage. Free health care insurance is provided for residents earning less than 150 percent of the federal poverty level if they are not eligible for Medicaid. Partial subsidies are provided for those earning up to 300 percent of the federal poverty level. The law also established a Commonwealth Health Insurance Connector Authority (Health Connector) which serves as an insurance broker to offer private insurance plans to Massachusetts residents. Tax penalties are in place for those who fail to enroll in a health insurance plan.

Much can be learned from the Massachusetts experience. Since the implementation of health care reform in the state, Massachusetts has seen its number of uninsured fall to 2.5 percent—the lowest in the nation. However, the cost of the plan is higher than expected due to more individuals receiving subsidies, the inclusion of prescription drugs as a benefit and health care costs rising faster than expected. In addition, the employer penalty fund is generating less revenue than anticipated. Access to care has also been an issue, with a shortage of primary care in some areas.

Massachusetts provides an indication of how expanded coverage will impact costs on a national scale. Massachusetts is currently engaged in a round of looking at cost controls and caps and how to deal with the problem of higher costs resulting from all of the people who have been added into the plan. Several pilots are being reviewed to determine how costs might be reduced through reorganization of the delivery system.

Unintended consequences also have occurred for some of the safety net providers who lost some of their state subsidies under the new insurance plan, but have not been made whole through the transition. In some cases, these safety net providers have disproportionately provided care for the remaining 2.5 percent of the uninsured.

### *Implications for Trustees*

With health care reform, trustees can expect their hospitals to care for more patients. Many of these patients may not have access to primary care physicians which could lead to emergency department overcrowding and require decisions about whether to increase hospital capacity. Trustees will be faced with two options to meet increasing demand: expand physical capacity or increase efficiencies through improved patient flow. Both approaches will have cost implications because even though there will be many new patients with coverage, hospitals can expect lower rates of reimbursement to care for these patients.

In the past, hospitals have been focused on revenue growth. However, the new demands of health care reform will require boards to shift their focus toward bringing down costs as

health care organizations are forced to match costs to revenue levels. Many hospitals are already looking at bringing their costs down to levels below their Medicare reimbursement in an effort to make money on Medicare. Revenue levels will continue to fall and hospitals and their boards will need to work aggressively on reducing costs, by becoming more efficient and improving patient flow.

## **Payment Reforms**

The second major area of impact in the health care reform bill focuses on changing how payment is made to hospitals and physicians. There are several components that deal with payment reform, each having implications for trustees.

### **Readmission Penalties**

One area of impact is readmission penalties for those hospitals with excess readmission rates nationally. Beginning in 2013, there will be penalties for excess readmissions when compared to expected levels of readmissions based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program. Critical access hospitals and post-acute care providers will be excluded.

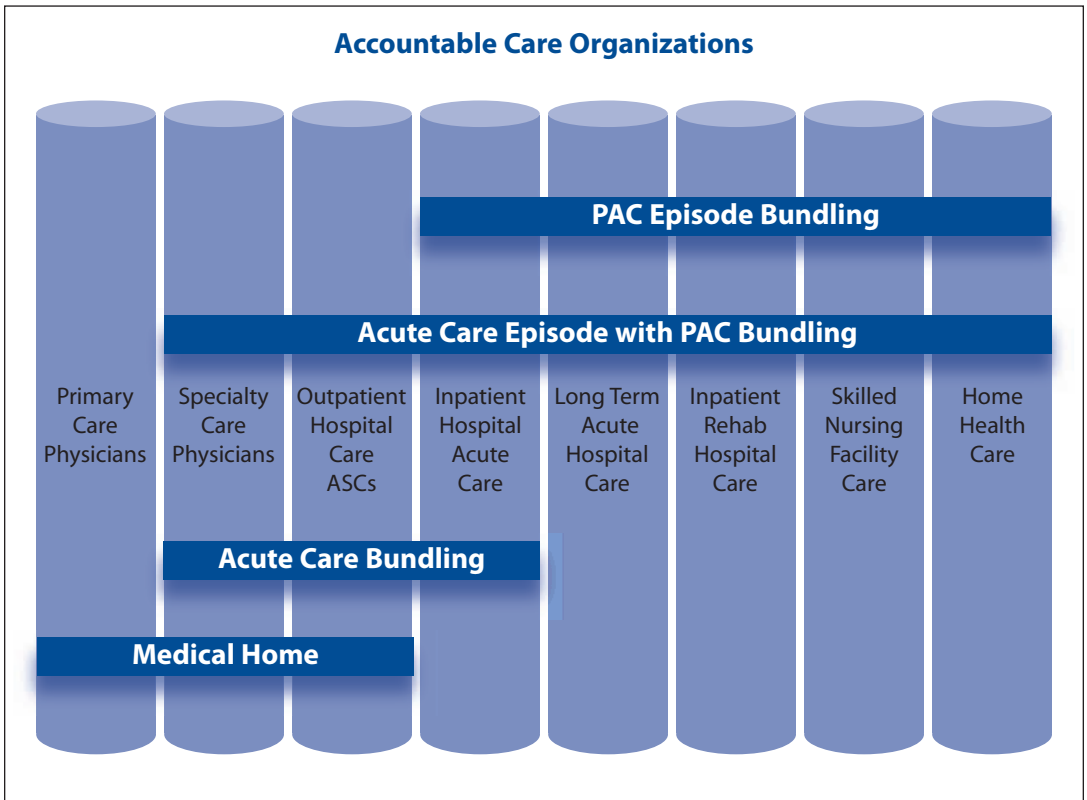
### **Bundling**

Beginning in 2013, the health care reform law requires the Secretary of Health and Human Services to establish a national, voluntary, five-year pilot program on bundling payments to hospitals, doctors and for post-acute care around 10 conditions. If successful, the Secretary may expand the pilot after 2015. The pilot is intended to encourage financial alignment that supports delivery system and process re-engineering to improve patient care quality and efficiency; allow for shared savings among health plans, providers, employers and patients to the extent that bundled reimbursement improves quality and efficiency; and develop and test solutions to bundled payment implementation issues.

Currently, there are many silos in the delivery of health care services—primary care, specialty care, outpatient care, inpatient care and a host of post-acute care services. The ACA addresses testing for different models of service delivery across these silos. Paying for larger units of service is meant to encourage coordination of care across the various venues for care delivery as shown in Figure 1 on page 6.

One concept to accomplish this is the Patient-Centered Medical Home model. Medical home models would create a bundle that includes primary care services, some specialty services and outpatient hospital care, including ambulatory surgery centers. Acute care bundling could combine inpatient acute care, outpatient hospital care, ambulatory surgery center services and specialty physician care. In this example, care would be bundled around the hospital admission, but does not include PAC (post-acute care) services. Acute care also

**Figure 1: Options for Payment Bundling**



could be bundled with post-acute services to include care provided by long-term acute care hospitals, inpatient rehabilitation hospitals, skilled nursing facilities and/or home health services.

This entire spectrum of care, across multiple settings, represents the concept of an Accountable Care Organization (ACO), a structure for care delivery that involves partnerships among hospitals, physicians and other providers who are jointly accountable for coordinating and delivering care to improve health care quality and slow the growth of health care costs. According to *Accountable Care Organizations*, an AHA research synthesis report, organizations that will be able to successfully participate in ACOs must have certain competencies. These include:

- Leadership;
- A culture of teamwork;
- Relationships with other providers;
- Information technology infrastructure for population management and care coordination;
- Infrastructure for monitoring, managing and reporting on quality;

- Ability to manage financial risk;
- Ability to receive and distribute payments or savings;
- Resources for patient education and support.

In May 2010, AHA also published a research synthesis report, *Bundled Payment*, which suggests the implications of bundled payments for hospitals. It examines the design and impact of certain bundled payment projects, and raises key issues for consideration, such as:

- What conditions should be bundled?
- What services should be included?
- How can provider accountability be determined?
- What capabilities are needed for organizations to administer a bundled payment?

#### *Implications for Trustees*

Trustees will need to understand the investments that need to be made to prevent readmissions and to improve care for patients after discharge. One useful resource is the *Health Care Leader Action Guide To Reduce Avoidable Readmissions* (A. Osei-Anto, M. Joshi, A.-M. Audet et al., Health Research & Educational Trust, The Commonwealth Fund, and the John A. Hartford Foundation, January 2010). It synthesizes the underlying strategies from the interventions that have been successful in reducing unplanned readmissions. The Guide is organized by the three stages of the care continuum: during hospitalization, at discharge, and the period immediately following discharge, and provides an evaluation of the level of effort required for implementation. For more information about the Guide go to [www.commonwealthfund.org/Content/Publications/Fund-Manuals/2010/Jan/Health-Care-Leader-Action-Guide.aspx](http://www.commonwealthfund.org/Content/Publications/Fund-Manuals/2010/Jan/Health-Care-Leader-Action-Guide.aspx).

In an environment of payment bundling, trustees will need to develop a better understanding of at-risk payment and to think about the metrics that should be used to evaluate success with this form of reimbursement. Trustees can begin to gauge their organization's readiness for bundling by considering where their organizations are at-risk today for payment linked to their quality and safety performance. An organization's current rate of recapture for at-risk payments can be a useful metric. Is your hospital recovering 80 percent of its at-risk money, or only 40 or even 20 percent? The current rate of recovery can help hospital leaders, including the board, determine how their hospitals might perform under a bundled payment system and identify opportunities for improving today's rate that could translate into better future performance as well.

Bundling will also require hospitals and their boards to develop new skills for partnering with other providers, including physicians and long-term care facilities. Some potential partners will have the same mission, business imperatives or business model as your health

care organization—some may not. The issue for governance becomes: What are our principles for partnering? Designing a set of principles to guide these decisions can help the organization select suitable partners to successfully manage the newly designed health care system.

## **Delivery System Reforms**

Health care reform will result in significant changes in the delivery system, including models such as Accountable Care Organizations. Beginning in 2012, hospitals can share savings with Medicare under one form of ACO. Medicare will partner with hospitals, physicians and other providers and identify costs for serving a defined population of Medicare patients for which providers will be accountable. If the providers save money on delivering care to that population, they can split it with Medicare. This approach is slightly different from the more traditional or academic concept of an ACO in which a group of providers assumes full risk for a population of patients for which they provide contracted services.

Another critical element of delivery system reform is the Center for Medicare and Medicaid Innovation. Beginning in January, 2011, there will be opportunities to test innovative payment and service delivery models through the Center, which may allow hospitals to participate in some of the new approaches to service delivery in which providers share risk both up and down the continuum of care.

Two additional new approaches to care and service delivery are the Patient-Centered Medical Home (PCMH) and the Independence at Home (IAH) models. The Patient-Centered Medical Home provides comprehensive primary care for children, youth and adults. It is a health care setting designed to facilitate partnerships between patients, their physicians and—as appropriate—their families. Grants are available for creating community-based interdisciplinary health teams to support primary care and capitated payments to primary care providers.

The Independence at Home demonstration project, beginning in January, 2012, will target physicians and nurse practitioner home-based primary care teams for high-risk patients. The project is designed to determine whether providing home-based primary care services to Medicare enrollees with multiple chronic conditions will improve patient outcomes and reduce costs due to decreased hospitalizations and emergency department visits. If these teams are successful in reducing Medicare costs by at least five percent compared to more traditional care, the teams will receive a share of any savings beyond that threshold.

Delivery system reform will challenge organizations to achieve integration. They must also accept risk and management of the continuum of care, including patients with chronic diseases, as well as build quality and system improvement into everything they do.

### *Implications for Trustees*

The concept of hospital integration is built into many of the pilots that are part of the legislation. Integration will require new skills and new methods of care management. Trustees need to be well-informed about what their organizations are doing to become more efficient, to improve outcomes and to ensure the appropriate infrastructure is in place to support these efforts. This does not mean trustees should be involved in the organization's day-to-day operations. Rather, they should be asking questions about what the hospital needs to do to reduce costs and improve outcomes. For example, the board might ask: "Does our organization have adequate IT and other support to make patient flow easier and to manage the transitions between all of the silos of care? How can our hospital most effectively measure outcomes across the continuum rather than just in inpatient settings?" Once a course of action is identified, the board then needs to allocate resources to get the job done.

Hospitals also must rethink their governance models. New structures may involve shared governance with organizations that have traditionally not been hospital partners. New skills and competencies will be needed among board members to facilitate these collaborations and partnerships. New initiatives that move away from the current focus on sick and acute care to maintaining health and wellness across the continuum for a community also must be developed. Hospitals will need to explore opportunities to bring the community into the work they are doing, particularly related to governance.

All of these changes, new opportunities and challenges require a different way of thinking. Trustees must move beyond the current model of primarily treating individuals who are acutely ill to thinking about community health and taking care of large populations of patients.

## **Quality and Patient Safety**

An increasing need for performance transparency is built into the health reform legislation, prompted by greater public scrutiny of hospital performance, increased requirements for hospitals and physicians to submit performance data to payers and regulators, and provider payments increasingly tied to quality and safety performance. This focus will result in a significant amount of information on comparative effectiveness and how technology is being used—is technology adding efficiency or just cost? Hospitals also will need to look at whether or not they are providing disparate care—that is, whether or not the care they deliver results in the same kinds of patient outcomes with different populations of patients. In addition, hospitals will need to ensure they are reflecting the communities they serve in their governance structure and practices.

Value-based purchasing, which will be established in October 2012 for fiscal year 2013, is a budget-neutral program that will result in a redistribution of money. In fiscal year 2013, one percent of Medicare payments will be redistributed from bottom quartile performers to those in the top quartile. The performance period beginning in January 2011 will serve as the basis for these payments. By 2017, two percent of Medicare payments will be redistributed.

This focus on performance and the potential for both sanction and reward will increase this year as hospitals and their boards begin to review new CMS performance measures and consider how they will impact the organization's quality and financial outcomes.

**Figure 2: Current CMS Performance Measures**

Current CMS Reporting	
<p><b>Heart Attack (Acute Myocardial Infarction)</b></p> <ul style="list-style-type: none"> <li>• Aspirin at arrival</li> <li>• Aspirin prescribed at discharge</li> <li>• ACE inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction</li> <li>• Beta blocker at arrival</li> <li>• Beta blocker prescribed at discharge</li> <li>• Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival</li> <li>• Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)</li> <li>• Adult smoking cessation advice/counseling</li> </ul> <p><b>Heart Failure (HF)</b></p> <ul style="list-style-type: none"> <li>• Left ventricular function assessment</li> <li>• ACE inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction</li> <li>• Discharge instructions</li> <li>• Adult smoking cessation advice/counseling</li> </ul> <p><b>Pneumonia (PNE)</b></p> <ul style="list-style-type: none"> <li>• <b>Timing of receipt of initial antibiotic following hospital arrival</b></li> <li>• Pneumococcal vaccination status</li> <li>• Blood culture performed before first antibiotic received in hospital</li> <li>• Adult smoking cessation advice/counseling</li> <li>• <b>Appropriate initial antibiotic selection</b></li> <li>• Influenza vaccination status</li> </ul>	<p><b>Surgical Care Improvement Project (SCIP)</b></p> <ul style="list-style-type: none"> <li>• Prophylactic antibiotic received within 1 hour prior to surgical incision</li> <li>• Prophylactic antibiotics discontinued within 24 hours after surgery end time</li> <li>• SCIP-VTE 1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients</li> <li>• SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery</li> <li>• SCIP Infection 2: Prophylactic antibiotic selection for surgical patients</li> <li>• SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose</li> <li>• SCIP Infection 6: Surgery Patients with Appropriate Hair Removal</li> </ul> <p><b>Mortality Measures</b></p> <ul style="list-style-type: none"> <li>• Acute Myocardial Infarction 30-day mortality (Medicare patients)</li> <li>• Health Failure 30-day mortality (Medicare patients)</li> <li>• Pneumonia 30-day mortality (Medicare patients)</li> </ul> <p><b>Patients' Experience of Care</b></p> <ul style="list-style-type: none"> <li>• HCAHPS Patient Survey</li> </ul>

Figure 2 shows examples of the measures that are currently required for CMS reporting. Trustees are now familiar with reviewing measures such as those related to heart attack, heart failure, pneumonia, surgical care improvement, mortality and the patient experience. Moving forward, hospitals will be required to report on new measures (see Figure 3 on page 11) that also will be tied to the potential for payment losses and gains based on performance.

Hospital-acquired conditions will be a heightened area of focus, beginning in 2015. There will be an additional one percent penalty to hospitals with the highest rates; those in the top quartile will see \$1.5 billion in payment reductions over 10 years.

**Figure 3: New CMS Performance Measures**

<b>New CMS Measures for 2010</b>	
<p><b>Surgical Care Improvement Project (SCIP) Measure:</b></p> <ul style="list-style-type: none"><li>• SCIP Cardiovascular<sup>2</sup>, surgery patients on a beta blocker prior to arrival who received a beta blocker during the peri-operative period</li></ul> <p><b>Re-admission Measure:</b></p> <ul style="list-style-type: none"><li>• Heart failure (HF) 30-day risk standardized re-admission measure (Medicare patients)</li></ul> <p><b>Nursing Sensitive Measure:</b></p> <ul style="list-style-type: none"><li>• Failure to rescue (Medicare patients)</li></ul>	<p><b>AHRQ Patient Safety and Inpatient Quality Indicator Measures (9):</b></p> <ul style="list-style-type: none"><li>• Patient Safety Indicators (PSIs)</li><li>• Death among surgical patients with treatable serious complications</li><li>• Iatrogenic pneumothorax, adult</li><li>• Postoperative wound dehiscence</li><li>• Accidental puncture or laceration</li><li>• Inpatient Quality Indicator Measures</li><li>• Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)</li><li>• Hip fracture mortality rate</li><li>• Mortality for selected medical conditions (composite)</li><li>• Mortality for selected surgical procedures (composite)</li><li>• Complication/patient safety for selected indicators (composite)</li></ul> <p><b>Cardiac Surgery Measure:</b></p> <ul style="list-style-type: none"><li>• Participation in a systematic database for cardiac surgery</li></ul>

### *Implications for Trustees*

Trustees must be concerned, not necessarily with each individual performance metric, but with how overall performance at certain quartiles will affect payments. They must also look beyond the numbers to determine why specific results are occurring. If readmissions are high, why are they high? Are sufficient investments being made in discharge planning, care coordination, post-acute care and the management of care outside the hospital's walls, or are readmissions being allowed to occur and result in reduced payments and lost revenue? If a portion of these potential losses were reinvested, how might that investment impact overall reimbursement levels? In short, where are the risks and how might those risks be effectively managed?

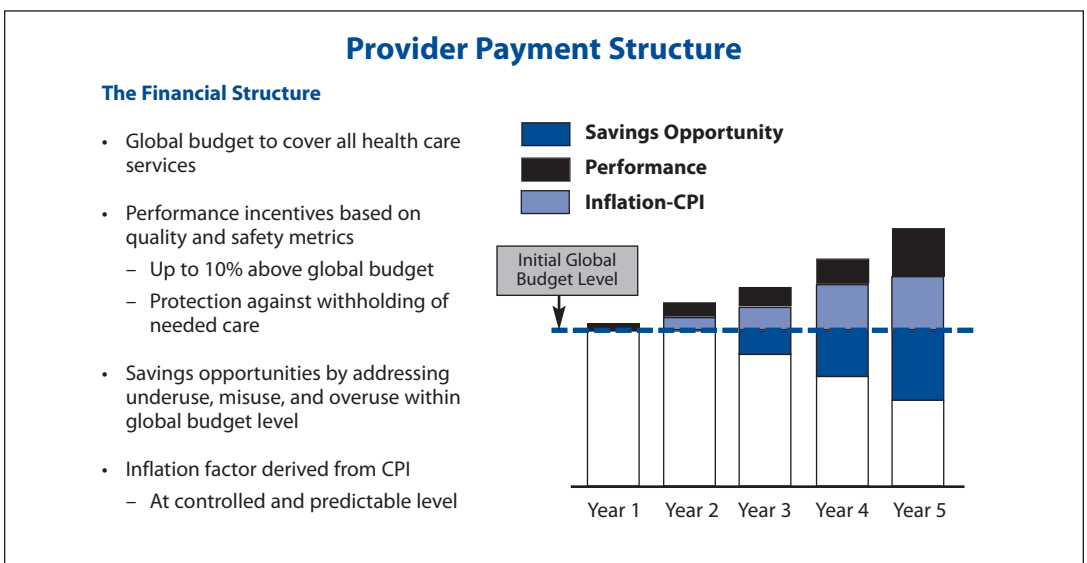
Governance in an environment of heightened risk requires a new mindset. For example, consider the evidence now available that is compelling us to reconsider the traditional view that hospital complications are bound to occur at some level due to the complexity of medicine. Hospitals that have made great strides in eliminating certain complications for long periods of time are helping all of us to shift our thinking toward the reality that these complications can be reduced to zero. Believing that complications can, in fact, be eliminated can lead to establishing an accountability structure to meet this new expectation for our health care organizations. For example, seven years ago it was widely believed that central line associated bloodstream infections could never be reduced to zero. But, today, many organizations have done just that. Technology didn't change. Science didn't change. What changed was the expectation and understanding that this level of performance was possible. A key role for trustees is to serve as the catalyst that drives these changing expectations about hospital quality and safety performance.

## Physician Relationships

To accomplish the dramatic changes that health care reform will demand, hospitals need to become better partners with physicians. Hospitals must move from viewing physicians as their customers, to viewing physicians as partners in the delivery of care. Health care reform offers several opportunities to develop a new perspective on partnering with physicians around bundling of payments, Accountable Care Organizations, Medicare and Medicaid Innovation Center pilots and new policies that encourage hospitals to reach out and engage physicians in quality and safety work to succeed in value-based purchasing and reducing readmissions and hospital-acquired conditions. There will be new opportunities to reach out to other providers to care for patients using the medical home and independence at home models of care delivery as well.

Don Berwick, formerly the head of the Institute for Healthcare Improvement (IHI) and now the head of CMS, developed the concept of the triple aim: to improve the health of the population, to improve the patient experience, and to reduce costs. CMS is likely to take these concepts developed at IHI and pilot them through the Center for Medicare and Medicaid Innovation to create new ways to manage population health. If hospitals can reduce the costs of providing hospital-based care, more money will be available for preventive care programs and initiatives that support good health, rather than just sick care. In fact, there is already a payment mechanism to fund Accountable Care Organizations in the Massachusetts Blue Cross/Blue Shield alternative quality contract, as outlined in Figure 4.

**Figure 4: The Massachusetts Blue Cross/Blue Shield Alternative Quality Contract**



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In Massachusetts, Blue Cross/Blue Shield has contracted with networks of hospitals and physicians to provide a set of services to a risk-adjusted list of subscribers. The five-year contract is based on current rates; however, instead of inflating the rate each year by the medical price index, the inflated rates are based on the consumer price index, which is currently very low. Blue Cross/Blue Shield holds back the difference between that rate and the medical inflation rate and hospitals can recover that amount if they achieve certain negotiated quality gains. They can also make money by becoming more efficient. So far, hospitals are not doing badly under this model. It remains to be seen what will happen after five years when Blue Cross/Blue Shield comes back to negotiate a rebased rate for these contracts, but for now it seems to be working well. The alternative quality contract is one approach to providing payment to an Accountable Care Organization and is a good reflection of what the future will hold as health care reform progresses.

### **Physicians as Partners**

Physicians and hospitals are re-examining their respective strategic and operating roles in light of the changing landscape to:

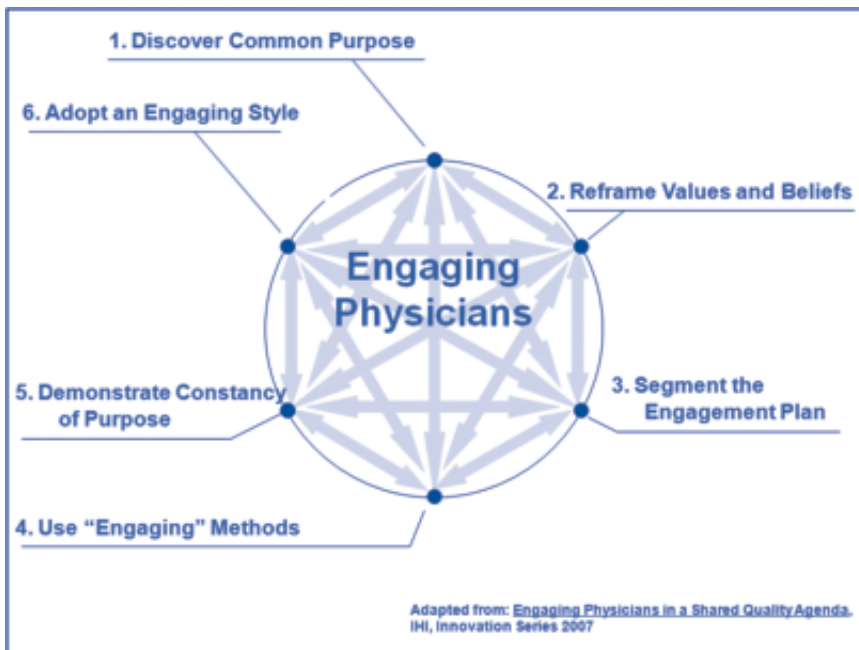
- Improve quality and safety of care while achieving cost containment.
- Develop new patient care models.
- Evaluate on-call coverage.
- Assess local competition.
- Manage the regulatory environment, including specialty services, reporting and payment.

To be successful in the emerging environment of reform hospitals will need to collaborate with physicians to manage the health of patient populations outside of the hospital and to develop new care models to improve quality and safety, while reducing costs. Better measurement systems and stronger partnerships will be required; and physicians will need to have access to and fully understand, both health care quality and cost information, which represents a departure from past practice.

Historically, relationships with physicians have been all about structure and control. In the 1990s during the physician-hospital organization movement, the biggest debate was over how many board seats would be held by physicians and how many by hospitals. Distrust abounded. In the future there is likely to be a movement away from structure and control to accountability and performance. Hospitals and physicians will come together in a structure that provides for mutual accountability and requires documented performance on both sides.

A 2007 IHI white paper that discusses strategies for hospitals to engage physicians in quality also provides a useful framework for engaging physicians for success under health reform. Figure 5 on page 14 identifies each of these strategies, which are discussed in more detail below.

**Figure 5: Strategies for Engaging Physicians**



### *Common Purpose*

Hospitals and physicians both want to improve patient outcomes and create a culture that is patient-focused. In pursuing this common purpose, hospitals also can help physicians become more efficient and streamline the process of care delivery.

### *Values and Beliefs*

To work together effectively, both hospitals and physicians need to reframe their values and beliefs about how they should collaborate. Hospitals need to view physicians, not as customers, but as partners who share their expectations, beliefs and values and who work with them to improve patient care, understanding that both parties have responsibilities for quality at a system level and at an individual level.

### *Segment the Engagement Plan*

As hospitals move forward with these new models they must start to drive change by focusing on those physicians that are already on board and ready to embrace new opportunities and then bring others along as programs develop and results are achieved. Hospitals also need to acknowledge that their medical staffs each include a diverse population of physicians, who may have different needs based on age or specialty or the various roles they want to play in working to improve care quality and safety. This means hospitals will need to work with different types of physicians in different ways to engage them in improvement efforts.

### *Use Engaging Methods*

Physicians are often said to be data-driven or responsive to data in analyzing problems and seeking solutions. However, physicians are not likely to respond well to data that will either embarrass them or put them in a defensive position. Data should be used to generate light, not heat. Hospitals should use data to help physicians better understand quality and safety performance, but not in a way that is designed to criticize them for their performance.

### *Constancy of Purpose*

Expectations and accountability must be established at the board level and applied consistently across the organization. Physicians want to understand the hospital's mission and focus and know that the organization is going to stay the course. Trust erodes if the board and leadership behave in ways that are inconsistent with the hospital's mission and values.

### *Adopt an Engaging Style*

Physicians must be involved at the beginning of quality and safety improvement efforts to build trust. Hospitals should work with physician leaders and early adopters, ensuring physician involvement is visible and building trust with each initiative. Communication should be candid and frequent.

## **Physician Compacts**

Physician compacts are formal documents that outline the expectations that hospitals and physicians have for each other and the responsibilities each party will undertake. They are designed to reframe the hospital-physician relationship to move beyond past issues of autonomy, protection and entitlement to emphasize mutual interdependence and accountability. (For examples of hospital-physician compacts visit [www.americangovernance.com](http://www.americangovernance.com).)

Hospitals and physicians also need to invest time and other resources in developing physician leaders, and the board must hold the organization accountable. Just as hospitals create succession and development plans for administrative leaders, there should also be similar processes for identifying and developing physician leaders.

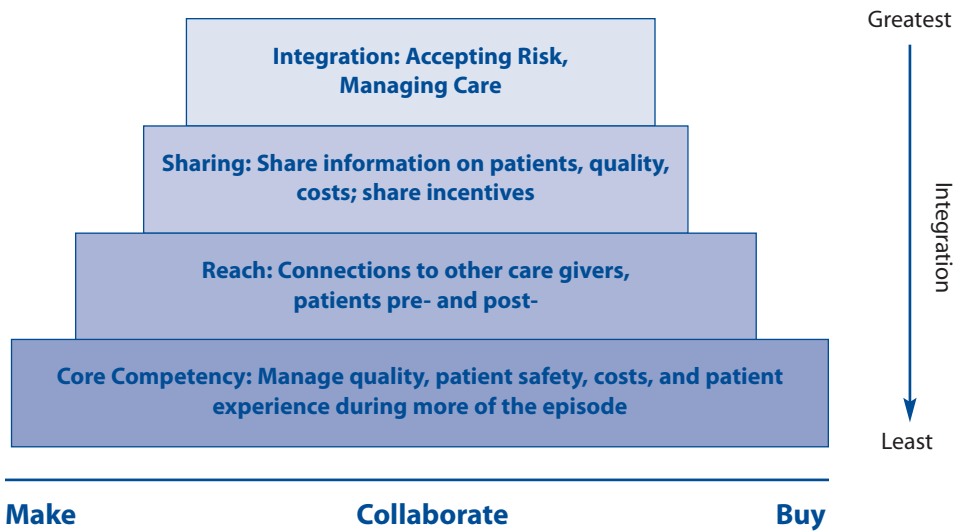
### *Implications for Trustees*

In preparation for the impacts of health care reform, boards should be focused on strengthening physician relationships. Trustees should work with hospital executives and the medical staff to establish a working group to examine issues related to fostering collaboration, developing mutual goals and strengthening alignment with physicians through establishing a new compact specifically focused on hospital and physician expectations and responsibilities in the reformed delivery system.

## Summary

What will the future look like? The answers are uncertain, but hospitals and other providers will have many opportunities to position themselves to succeed in the new environment as suggested in Figure 6.

**Figure 6: Positioning for Success in an Environment of Reform**



Hospitals will need to strengthen their core competencies, at both board and leadership levels, to better care for patients inside and outside the hospital setting. They will need to understand how to measure, monitor and improve quality, safety, costs and patient satisfaction across multiple settings. To do this effectively, hospitals will need information systems that enable sharing of performance data and results across sites and providers, a corporate culture that promotes teamwork, and a management and oversight infrastructure that supports quality improvement and cost efficiency.

Many hospitals may choose to establish relationships with physicians, post-acute care organizations and other providers in their communities that allow for information sharing as well as coordinated efforts to address community-wide problems. Some may choose to develop formal relationships, such as establishing an ACO with other providers to deliver services and share risk and incentives.

Regardless of where hospitals choose to position themselves among these options, they will need to better understand how well patients are being cared for across the continuum—before, during and after they leave the hospital. Governing boards, executives and physician

leaders also will need to build partnerships based on mutual goals, teamwork and accountability as they work together to answer, the question: “How can we demonstrate true value by delivering care and service that is cost-effective and results in better quality and safety outcomes for our patients?”

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